STATE OF CONNECTICUT
OFFICE OF POLICY AND MANAGEMENT

TESTIMONY PRESENTED TO THE HUMAN SERVICES COMMITTEE
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Testimony Supporting Senate Bill No. 32

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS CONCERNING SOCIAL SERVICES

Senator Doyle, Representative Walker and distinguished members of the Human Services Committee, thank you for the opportunity to offer written testimony on Senate Bill No. 32, AA Implementing the Governor's Budget Recommendations Concerning Social Services.

In general, the initiatives in this bill will result in savings of $74.9 million in FY 11.

In addition, the bill reverses the delay of HUSKY capitation payments ($72.5 million), allows for Medicaid certification of intermediate care beds for mentally ill patients ($2.5 million), and establishes a Department on Aging ($500,000), which will result in additional costs of $75.5 million in FY 11.

This bill makes the following changes:

Sections 1 – 19, 64 and 68. Establish Department on Aging. These sections of the bill codify the establishment of the Department on Aging (DOA) effective July 1, 2010. The bill directs the Department of Social Services (DSS) to continue to administer programs under the department's Aging Services Division until such time as a commissioner of DOA is appointed and staff persons are hired. Once the new agency is fully operational, the bill authorizes the Governor to exercise her existing statutory authority to transfer funding for functions, powers, duties and personnel of DSS' Aging Services Division to DOA (with the approval of the Finance Advisory Committee). Establishing DOA will result in an additional cost of $452,866 in FY 11.

Note: Section 4 (which transfers an adult foster care program from DSS to DOA) should be stricken and section 17b-424 of the general statutes should be added to the list of sections being repealed under section 68 of this bill. DSS is currently phasing out the adult foster care program due to its low participation rate (only two clients remain).

Sections 20 – 27, 65 and 66. Transfer the Functions of the Commission on the Deaf and Hearing Impaired to DSS. These sections of the bill consolidate services of the Commission on the Deaf and Hearing Impaired (CDHI) with the Department of Social Services. The interpreting, counseling, and management units of CDHI will be transferred to DSS. Savings of $260,000 in FY 11 are anticipated.

Section 28. Allow for the Certification of Intermediate Care Beds. Public Act 09-5, September special session, allows DSS to amend the Medicaid state plan to create a per diem rate for intermediate care beds for mentally ill patients in general hospitals. As a result, DSS will be submitting a state plan amendment to the Centers for Medicare and Medicaid Services to allow the state to establish a per diem rate that is exempt from the TEFRA reconciliation process for intermediate care psychiatric units certified by the Department of Mental Health and Addiction Services. This bill will allow the Department of Mental Health and Addiction Services to certify the need for intermediate care capacity in general hospitals. These intermediate care beds are necessary to support the closure of Cedarcrest Hospital because they will allow access to services that are being lost in the closure. It is anticipated that a condition of Certificate of Need (CON) approval will be successful development of these intermediate care beds. DMHAS' recommended budget includes $2.5 million to support this initiative.

Section 29. Restructure HUSKY B Cost-Sharing. This section of the bill implements two provisions included in the Governor's budget:

1. Align HUSKY B Co-Pay Requirements to State Employee Health Plans. Currently, the HUSKY B program includes cost sharing requirements consistent with the co-pay requirements that were in place for state employees at the time that HUSKY B was developed. Under this bill, HUSKY B co-pay requirements will be re-aligned to remain consistent with current and future co-pay requirements. Savings of $710,000 in FY 11 are anticipated.
2. Modify Premium Payment Requirements under HUSKY B. The HUSKY B program provides health insurance for uninsured children up to age 19, regardless of family income. Children with family incomes between 185% and 235% of the federal poverty level can receive health insurance without a monthly premium co-payment. For those children with family income between 235% and 300% of the federal poverty level, a monthly premium cost sharing of $30 per child, up to a maximum of $50 per family, is required. Children in families with incomes over 300% of the federal poverty level pay the full premium. Under this bill, monthly premiums for Band 2 will increase to $50 for families with one child and $75 for families with two or more children. Total cost-sharing (co-pays and premiums) cannot exceed 5% of the family's income. Savings of $1.4 million in FY 11 are anticipated.

Section 30. Restrict Vision Services for Adults under Medicaid. The provision of eyeglasses, contact lenses and services provided by opticians and certain optometrists (depending on where the services are provided) are considered optional under federal Medicaid rules. Under this bill, DSS will no longer provide coverage of eyeglasses, contact lenses and services provided by opticians and certain optometrists under Medicaid. DSS will continue to provide coverage of services provided by ophthalmologists. To comply with federal rules, the current benefit will continue to be provided to all children under the age of 21 under the HUSKY A program. Savings of $4.6 million in FY 11 are anticipated.

Note: A technical correction to the bill is required - line 927 should be amended by inserting the words "optometrist or" before "optician."

Section 31. Eliminate Coverage of Most Over-the-Counter Drugs. This provision eliminates coverage of over-the-counter drugs, with the exception of insulin and insulin syringes, under the department's pharmacy programs. This change is consistent with the current policy under the ConnPACE program. To comply with federal rules, Connecticut will continue to provide coverage of over-the-counter drugs to all children under the age of 21 under the HUSKY A program. Savings of $7.7 million in FY 11 are anticipated.

Section 32. Conform Payment of SSI Attorney Fees to Allowable Federal Law. The federal government sets reasonable caps on the amount an attorney may earn from representing a client in the appeal of a denial or termination of Supplemental Security Income (SSI) and/or Social Security (SSA) benefits. Although the Social Security Administration allows attorney fees to be deducted from an individual's successful appeal, DSS allows attorneys to be paid from the General Fund, rather than seek reimbursement from the client's retroactive benefit received from a successful appeal. This bill will allow for an attorney representing a client appealing to the Social Security Administration to affirmatively seek an assignment from the individual's SSA/SSI benefit. Under this bill, attorneys will need to avail themselves of the SSA program as DSS will no longer pay their fees. Savings of $200,000 in FY 11 are anticipated.

Section 33. Expand DSS' Preferred Drug List to Include All Mental Health Drugs. Last year, the Governor's budget had included savings associated with adding mental health related drugs to the preferred drug list (PDL) in order to receive supplemental rebates on these drugs. The legislature modified the Governor's proposal by requiring that only new mental health prescriptions be subject to the PDL process, exempting existing mental health prescriptions. Under this bill, all mental health prescriptions will be subject to the preferred drug list in order to receive supplemental rebates on these drugs. For coverage of drugs that are not on the PDL, the extra step of receiving prior authorization will be required. Clients will continue to receive their necessary medications. Savings of $1.0 million in FY 11 are anticipated.

Section 34. Impose Cost-Sharing Requirements on Certain Individuals Receiving Medicaid Services. According to a report by the Kaiser Family Foundation, a total of 45 states impose co-payments under their Medicaid programs. Under this bill, DSS will require co-pays of up to $3.00 per service on allowable medical services (excluding hospital inpatient, emergency room, home health, laboratory and transportation services), not to exceed 5% of family income. Co-pays for pharmacy services will be capped at $20 per month. Consistent with federal rules, the following populations will be exempt from the cost sharing requirement: certain children under age 18; individuals at or below 100% of the federal poverty level; Supplemental Security Income (SSI) recipients; pregnant women; women being treated for breast or cervical cancer; and persons in institutional settings. Savings of $9.0 million in FY 11 are anticipated.

Section 35. Revise Medicare Part D Co-Pay Requirements for Dually Eligible Clients. As of 2007, Connecticut was one of only eight states covering the costs of the Medicare Part D copayments for persons dually eligible for Medicare and Medicaid. The costs of the Part D prescription co-pays range from $1.10 to $6.30 in 2010. Last year, the Governor recommended that dually eligible clients be responsible for paying up to $20 per month in Medicare co-pays for Part D-covered drugs. The legislature modified the Governor's proposal by reducing the cap on these co-pays to $15 per month. Under this

bill, dually eligible clients will be responsible for paying up to $20 per month in Medicare co-pays for Part D-covered drugs. Savings of $1.1 million in FY 11 are anticipated.

Sections 36 and 67. Update Definition of Medical Necessity under Medicaid. The current medical necessity and appropriateness definitions under Medicaid establish an unreasonably high standard of services necessary to achieve "optimal" functioning and fail to provide for the application of medical evidence in medical review decisions. Last year, the Governor recommended replacing these outdated definitions with the definition being used under the State Administered General Assistance (SAGA) program since January 2005. The new definition combines the concepts of medical necessity and appropriateness as is done in Medicare and under public sector and commercial health care programs. The proposed definition incorporates the principle of providing services which are "reasonable and necessary" or "appropriate" in light of clinical standards of practice. Eliminating "maintaining an optimal level of health" will help to eliminate varying interpretations, which often result in levels of care that well exceed the definition of medical appropriateness. The legislature modified the Governor's proposal by establishing an oversight committee to advise DSS and reducing the annualized savings by 50%. Under this proposal, the definition for medical necessity and appropriateness will be delineated in legislation and the savings will be increased to the $9.0 million originally assumed in the Governor's proposal. Savings of $4.5 million in FY 11 are anticipated.

Section 37. Provide for Coverage of Medical Interpreters thru an Administrative Process. To improve access to health care for Medicaid clients with limited English proficiency, the legislature mandated that DSS amend the Medicaid state plan to include foreign language interpreter services provided to any beneficiary with limited English proficiency as a covered service under the Medicaid program. The enacted budget includes partial year funding in FY 11 of $2.5 million for this initiative, with annualized costs projected at $6.0 million. Under this bill, DSS will obtain these services from one centralized vendor. This is a more cost-efficient, streamlined model than requiring a Medicaid state plan amendment, where providers will be allowed to submit claims for reimbursement of medical interpreter costs. Providing services from one centralized vendor is expected to result in annualized costs of $1.7 million, significantly less than the $6.0 million projected under a state plan amendment. Savings of $1.8 million in FY 11 are anticipated.

Sections 38 – 40. Restructure Non-Emergency Medical Transportation under Medicaid. Current regulations require DSS to pay for ambulance service for individuals who are stretcher bound but do not require medical attention during transport. Under this proposal, transportation options under Medicaid will be expanded to include stretcher van service for those individuals who are medically stable but must lie flat during transport. The new stretcher van rate will be significantly less – roughly one-fifth of the non-emergency ambulance rate, which has a base rate of $218 plus $2.88 per mile (approximately $275 for a 20 mile one-way trip). This change is consistent with a number of other states that have recognized the economic value of stretcher vans. Savings of $5.9 million in FY 11 are anticipated.

Section 41. Reverse FY 11 Delay of HUSKY Capitation Payment. The enacted budget assumed one-time savings as a result of delaying the June 2011 HUSKY capitation

payment to July 2011. Based on the expectation that congressional action will extend the enhanced federal Medicaid match under ARRA thru FY 11, this delay will likely be in violation of ARRA provisions that require states to pay Medicaid bills within 30 days. As a result, this bill eliminates the provisions which would have delayed these payments. A total of $72.5 million in FY 11 has been added back to DSS' budget to ensure that the state adheres to existing ARRA rules.

Section 42. Expedite DSS' Ability to Implement Initiatives. This section allows DSS to implement various initiatives under this bill while in the process of developing policies and procedures in regulation. This is necessary to ensure savings are achievable in FY 11 and are not delayed until final approval of regulations implementing programmatic changes.

Section 43. Establish a New Medicaid Coverage Group for TB Patients in Statute. The enacted budget includes savings in the Department of Public Health as a result of establishing a coverage group under Medicaid for individuals with tuberculosis. Language, however, was not included in any of last year's implementer bills to establish this coverage group in statute. Under this bill, as currently drafted, DSS will amend the Medicaid state plan to provide coverage for the treatment of tuberculosis for individuals with incomes up to 300% of the federal poverty level.

Note: DPH currently assumes the costs of TB-related services for individuals without adequate insurance, regardless of income or assets. To ensure that DSS is able to maximize Medicaid reimbursement, DSS will submit a state plan amendment that disregards all income and resources. Thus, the following substitute language is needed to correct the bill: Delete the language on lines 1199 - 1201 and insert "the treatment of tuberculosis for any eligible person" in lieu thereof.

Section 44. Technical Correction to ConnPACE Open Enrollment Period. Public Act 09-5, September special session, includes language implementing an open enrollment period under ConnPACE from November 15 thru December 30. To comply with the original intent, this bill revises the enrollment period to be consistent with the open enrollment period under the Medicare Part D program, which runs from November 15 thru December 31.

Sections 45 - 63, and 68. Restructure Medical Programs. These sections of the bill implement three provisions included in the Governor's budget:

1. Convert HUSKY to a Non-Risk Model. While Connecticut's current managed care model within the Medicaid program was a positive development intended to reduce the cost while improving the quality of care, the current system has grown to unsustainable levels. In general, based on past practice, managed care plans contracting with DSS have administrative costs that exceed 11.5% of the total per member per month rate. Over the biennium, that added administrative cost is budgeted at over $185 million. This proposal revamps managed care from an "at risk" arrangement to a non-risk contract with the program continuing under an administrative services organization (ASO) arrangement. Savings of $28.8 million in FY 11 are anticipated.

   Note: Section 62 should be stricken and section 17b-28a of the general statutes should be added to the list of sections being repealed under section 68 of this bill. Section 17b-28a of the general statues is obsolete; the waiver application

development council and the Medicaid waiver unit that are referenced in this section do not exist.

2. Return SAGA to a Fee-for-Service Structure. When the State Administered General Assistance program was restructured in FY 04, it was envisioned that a contractor would be responsible for managing ancillary medical services as well as a fixed pool of dollars for primary care and specialty services. Despite the recent carve-out of pharmacy and dental services and the fact that primary care and specialty services are now reimbursed at the Medicaid rate under a fee-for-service arrangement, $2.8 million will be expended annually to cover the contractor's administrative costs. Under this bill, savings will be achieved by eliminating these administrative costs and processing all claims thru the Medicaid claims processing system at a significantly lower cost. The bill also allows DSS to enter into an ASO arrangement similar to what is being proposed under HUSKY. This change will have no impact on the ability of SAGA clients to receive the necessary medical care. Savings of $2.3 million in FY 11 are anticipated.

3. Remove Limited Vision and Non-Emergency Medical Transportation Benefits under SAGA. Coverage of non-emergency medical transportation and vision under SAGA had been eliminated in FY 02 and FY 03, respectively. The legislature partially restored these benefits in FY 07 by providing funding for limited benefits. Under this bill, these expanded benefits, with the exception of transportation for radiation oncology, chemotherapy and dialysis, are eliminated. Savings of $1.4 million in FY 11 are anticipated.

Section 57. Limit Premium Assistance under the Charter Oak Health Plan. The vast majority of individuals enrolled in the Charter Oak Health Plan receive premium assistance, which is to range from $50 to $175, depending on income. Under this bill, DSS will limit premium assistance in FY 11 to clients who are enrolled in the program as of June 30, 2010. Lower income individuals who choose to enroll in the Charter Oak Health Plan after June 30, 2010, will be responsible for the full premium costs. Savings of $4.2 million in FY 11 are anticipated.